DOCUMENT RESUME

ED 064 353 TM 001 521

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TITLE An Evaluation System for a Psychoeducational Treatment Program for Emotionally Disturbed Children.
PUB DATE Apr 72
NOTE 27p.; Paper presented at the annual meeting of the American Educational Research Association (Chicago, Illinois, April 1972)

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS *Behavioral Objectives; *Emotionally Disturbed Children; *Evaluation Methods; *Measurement Instruments; *Psychoeducational Processes; Rating Scales

ABSTRACT

A general description of an overall evaluation system which is being implemented in a center for emotionally disturbed children is presented. The system is based upon three types of activities: planning, monitoring, and appraising. The application of the system to the evaluation of direct services to children is outlined. The evaluation plan for the child treatment program involves five phases: intake, staffing, monitoring, termination, and tracking. Three periodic measurement instruments used during the monitoring process are discussed: a clinical behavioral scale completed by a psychologist; a behaviorally based instrument completed by trained evaluators; and a rating form completed jointly by a monitor and therapist(s). (Author/DB)

AN EVALUATION SYSTEM FOR A PSYCHOEDUCATIONAL TREATMENT PROGRAM FOR EMOTIONALLY DISTURBED CHILDREN*

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An Evaluational System for a Psychoeducational

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ABSTRACT

A general description of an overall evaluation system which is being implemented in a center for emotionally disturbed children is presented. The system is based upon three types of activities: planning, monitoring, and appraising. It is pointed out that in such a three-pronged model these activities are neither independent nor mutually exclusive; they are not only compatible, but mutually supportive. It is the interrelations of the three types of activities which produce the end product. Once the initial planning is completed, the model affords reassessing, modifying strategies, and reprogramming whenever desirable. Following decisions of reprogramming, the evaluative cycle repeats itself: planning, monitoring, and appraising. It is for this purpose that a well developed information exchange system within the center is needed. Such evaluative procedures make it possible to advantageously integrate data collection into the decision-making process.

The goals of the evaluation team are: 1) to assist in expressing questions to be answered and information to be obtained, 2) to collect the necessary information, and 3) to prepare the collected information in a form useful for decision makers for assessing decision alternatives. The information to be used in each component program is in the form of data that provide descriptions and judgments of anything which feeds into the program (antecedents), happens during it (transactions), and results from it (outcomes), along with the contingencies among these. The antecedents constitute a major contribution to the planning and development of the evaluation strategy(ies) to be subsequently employed. It is a function of the evaluation team to relate the transactions to the objectives and processes of each component. The concern with the output data is one of devising performance criteria, relating these data to the other two types of data, and formulating decisions regarding worth and attainment of component objectives.

The somewhat detailed application of the system to the evaluation of direct services to children is outlined. It is emphasized that the important prerequisites of an evaluation system of a child treatment program are that the system be easily implemented and clinically useful.

The evaluation plan for the child treatment program involves five phases: intake, staffing, monitoring, termination, and tracking. Through a problem check list, a language common to individuals of varying backgrounds, from parent to psychiatrist, is used through the first two phases. A second language, closely allied to that of the problem check list, in the form of a list of treatment objectives, provides a commonality among the Rutland Center professionals upon which a meaningful monitoring process has been

developed. Three periodic measurement instruments used during the monitoring process are discussed. One instrument, a clinical behavioral scale completed by a psychologist, measures the qualitative aspects of behavior; a second instrument, behaviorally based and completed by trained evaluators, measures the quantitative aspects of behavior; and a third instrument, a rating form jointly completed by a monitor and therapist(s), measures both aspects of behavior. All three instruments were developed from the two common languages mentioned previously.

It was discussed how the evaluation system provides for a periodic feedback of information which is useful in supporting decisions regarding the individual child and the treatment program. Such information, along with that obtained at intake, aids in deciding when the termination process should begin. It was discussed how further evaluation will be made during termination and after direct Center treatment ends.

AN EVALUATION SYSTEM FOR A PSYCHOEDUCATIONAL TREATMENT PROGRAM FOR EMOTIONALLY DISTURBED CHILDREN[1]

The Evaluation System: An Overview

A current thrust in the efforts at Rutland Center[2] is the development of an evaluation system. This system is considered an integral part of the overall project rather than an adjunct to it, and the evaluation personnel have taken, and are taking, an active role in the planning, monitoring, and appraising phases of all Center operations. Because of this total involvement the success of the evaluation system is dependent upon a well developed system of information exchange which enhances feedback and communication. The involvement of the evaluation team in the total project and its participation in the exchange of information are depicted in Figure 1. Note that the evaluation team is expected to provide evaluative services (in the form of planning, monitoring, and appraising) to each of four components: demonstration and dissemination, training, service-to-children, and service-to-parents. (Although data are collected for the purpose of demonstration and dissemination, the following comments in this section generally pertain to the other three components.)

Insert Figure 1 about here

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in a form useful for decision makers for assessing decision alternatives. The information to be used in each component program is in the form of data that provide descriptions and judgments of anything which feeds into the program (antecedents), happens during it (transactions), and results from it (outcomes), along with the contingencies among these (see Stake, 1967). The antecedents include such inputs as trainee, child, and parent characteristics, referral data, environmental factors, and the psycho-educational curriculum and techniques. These inputs constitute a major contribution to the planning and development of the evaluation strategy(ies) to be subsequently employed. Involved in the transactions are the processes and interactions within and among learning or training activities, individuals, and materials. It is a function of the evaluation team to relate such data to the objectives and processes of each component. The outputs pertain to the individual client, to the home, and to the Center. The concern with the output data is one of devising performance criteria, relating these data to the other two types of data, and supporting decisions regarding attainment of component objectives, need for treatment modification, need for reprogramming and recycling and readiness for termination of treatment.

The various functions and roles of the evaluation team within the framework of the Center are outlined in Figure 2. It is important to note that in the three-pronged model these three types of evaluation activities

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Insert Figure 2 about here

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are neither independent nor mutually exclusive; they are not only compatible, but mutually supportive. As with the three kinds of data used for the evalua-

[illegible] evaluations of the [illegible] of activities [illegible] [illegible] and needs. [illegible] the initial [illegible] is completed, the [illegible] [illegible] necessary, modifying the component strategies, and reprogramming [illegible] desirable. Following decisions of reprogramming, the evaluative cycle repeats itself: planning, monitoring, and [illegible]. It is for this purpose that a well developed information exchange system within the Center is needed. Such evaluative procedures make it possible to advantageously integrate data collection into the decision-making process.

Because of theoretical limitations, and for practical and ethical reasons (especially with regard to the service-to-children component), the evaluation plans do not call for a comparative assessment of treatments or curricula. That is, the system does not include what is found in typical "research" or "experimental" settings, namely, random samples, constant "treatment," controlled variables, and comparison or control groups. Rather, the concern is with detailed descriptions and observations of individuals or small classes. The position taken is similar to that of Cronbach (1963): the aim to compare one program with another should not dominate plans for evaluation; evaluation should be primarily concerned with the efforts of the program under study. Rutland Center effort is addressed to the question, "What changes can be observed in a certain kind of individual which can be attributed to an involvement in a certain kind of program intervention?" Some time ago, Luborsky (1959, p. 328) pointed out that, "It has yet to be demonstrated that control groups in psychotherapy research have a more than very limited usefulness." The literature of the past decade has not produced much evidence to the contrary.

The Rutland Center evaluation methodology is not necessarily designed to yield universally valid information: the focus is on these particular treatment processes, integral parts of this psychoeducational model. The emphasis in the evaluation program may be likened to a current emphasis (controversy?) in educational measurement namely, that of criterion-referenced measures. Rather than comparing the performance of individuals--trainess, children, parents -- in the Rutland program with other individuals (norm-referencing), criteria are being established for each individual; thus enabling the individual's progress to be assessed relative to himself. (This does not, of course, preclude the use of norm-referenced measures obtained from "standardized" tests to yield input data.) These criteria for attaining objectives are usually not determined until after the individual receiving services has entered the program and some assessment has been made. And the decision of whether or not an individual has attained a criterion established for him is based upon as much objective information as possible (test results, systematic observation, rating forms, etc.), supplemented by whatever clinical judgment is deemed pertinent. Such decisions are made, of course following discussions involving an evaluator, a teacher, a psychologist, a monitor, and anyone else who may be familiar with the individual.

The success of such an evaluation methodology is highly dependent upon explicit statements of the goals and objectives of each of the project components. The inputs, transactions, and outputs must directly relate to the general objectives of each component as well as to specific objectives associated with the individual trainee, child or parent. The inportance and role of the objectives are clearly reflected in the three-pronged model (planning, monitoring, appraising) discussed previously. The emphasis is on (measurable) objectives as guidelines for action, and on

meaningful observation and description in assessing an individual's progress, or lack of it.

Most of the evaluation effort extended to date has been focused on the treatment program for the service-to-children component. Considerable work has been done in planning for the evaluation of the effect of the Developmental Therapy[3]program on four classes of preschool emotionally disturbed children at Rutland Center. The remainder of this paper discusses the application of the evaluation system outlined above to a method of treatment designed to ameliorate the child's symptoms and to produce gains in those areas which are most debilitating to his functioning.

Evaluation of Service to Children

For an evaluation system to be employed in a treatment program it must not only be empirically sound but, more importantly, it must in the long run be useful for clinical practice. To be clinically useful, an evaluation system must be intimately tied to the philosophy and underlying theory upon which the treatment program is based. This has been particularly difficult for traditional treatment programs which focus exclusively on broad hypothetical constructs related to psychodynamics. The emphasis at Rutland Center, however, is on problem behaviors manifested, or perceived, in the home and/or the school. Having a problem behavior orientation instead of a mental illness framework has made it possible to develop specific behavioral objectives for treatment planning and for measurement purposes. Recognizing also that qualitative aspects of behavior are important, provision has been made in the evaluation system for the measurement of these aspects.

In addition to the need for consonance with a theoretical base, an evaluation system must be composed of procedures that can blend smoothly into the everyday functioning of a treatment center. Any system that takes an inordinate amount of extra effort and does not facilitate the treatment function will soon be discarded. Practicing educators, psychologists, and social workers need evaluation procedures with which they can be comfortable and which help them be more effective in dealing with children's problems.

Thus, to be effective, an evaluation system must be built into the treatment program itself. Objective delineation of problems, setting of treatment goals, periodic assessment of progress, and the utilization of objective or quasi-objective[4] data for making treatment decisions should be not only qualities of a useful evaluation system but also necessary characteristics of any productive treatment program for children.

The general goal of the service-to-children component is: to provide psychoeducational treatment experiences to referred children so as to enable them to better cope with their home and school environments. Measurable outcome objectives for the children involve decreasing the number and/or severity of behavioral problems, and improving appropriate skills in curriculum areas of the psychoeducational process.

Structuring of the Treatment Program

The development of measurable objectives is essential if an evaluation system is to assist in the planning and maintenance of the treatment program for children. However, since the philosophy of treatment here is not strictly behavioristic, a potential difficulty existed at the outset. It was felt that the objectives must reflect both the developmental aspects

of the treatment model and the qualitative aspects of behavior, and at the same time maintain a sufficiently behavioral orientation to allow for somewhat objective and reliable measurement. Extreme specificity in the statement of objectives would have had a limiting effect on the psychoeducational therapists, while over-generalization would have made the objectives difficult to assess.

From this demand for a balanced approach, the list of representative objectives[5] resulted. These objectives provide behavioral milestones around which the treatment program of a child can be planned and monitored. The objectives range from simple attending and responding behavior necessary for any constructive child-environment interaction to more complex social skills such as those involving leadership behavior. They were developed around the four curriculum areas of Developmental Therapy: behavior, communication, socialization, and school readiness... An attempt has been made to specify the hierarchical order in which these behavioral objectives appear in the developmental process. This list serves as a common language useful for the purpose of outlining measurement procedures and constructing data collection instruments. This commonal ty maximizes communication among the various staff members involved in the periodic measurement process.

The Evaluation Plan

The evaluation plan for the service-to-children component is viewed as consisting of five major phases which coincide with the flow of diagnostic and therapeutic procedures of the treatment program. The phases are intake, staffing, monitoring, termination, and tracking. Each phase

is directly supported by data collected and summarized by the evaluation team (see Figure 3). The evaluation team assists in the delineation of

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Insert Figure 3 about here

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the child's problems during intake and staffing, provides periodic feedback information necessary for maintaining and adjusting the treatment program, assists in specifying termination criteria, and obtains follow-up information after direct Center treatment ends.

The evaluation and monitoring effort begins with the initial contact with parents and regular teacher and ends approximately one year after the child has been terminated from the treatment program. Throughout the diagnostic, staffing, and treatment phases of the program the evaluation system yields important informational feedback to the professional staff. All of the professional staff members participate in the development of procedures which provide the required data. These procedures are aimed at increasing the amount and usefulness of objective and quasi-objective data employed in making clinical judgments.

Intake and Staffing

Many multi-disciplinary treatment teams have found it difficult to delineate problem areas to the satisfaction of all involved. A common language, which facilitates communication among educators, psychologists, psychiatrists, social workers, measurement personnel, parents and regular classroom teachers, is essential if a child is to receive maximum benefits of a treatment program. Provision for such a common language in the deli-

neation of children's problem areas is made by the Referral Form Check List (RFCL).

The RFCL is a composite of behavior problems abstracted from referral records accumulated over a two-year period. The treatment files were reviewed, and all referral problems for preschool and primary school children were listed. Over 200 behavior problems were recorded; from this list many were eliminated because of duplication of problem meaning. This synthesis resulted in the check list, which is composed of 54 behavior problems grouped within the four curriculum areas of Developmental Therapy. A review of the literature (e.g., Peterson and Quay, 1967; Kooi and Schutz, 1965; Schrupp and Gjerde, 1953) indicated that the RFCL contained characteristics which are identical or parallel to those that have been previously investigated. A five-point rating scale format, ranging from "High Priority Problem" to "Not a Problem or Not Noticed" was selected because such a format (a) provides a range for detection of behavioral change over time, (b) allows for recognition of problems perceived by adults as "real" adjustment problems, and (c) permits the incorporation of clinical inference in the judgment process.

Investigation of reliability of the RFCL is currently in progress. Inter-observer reliability estimates have been obtained using an intra-professional group (i.e., educators, psychologists, etc.) orientation. Initial results are encouraging. Using the coefficient suggested by Ebel (1951), reliability estimates range from .46 to .76 across professional groups.

During the intake procedure, ratings on the RFCL are obtained from each staff member who is involved in the diagnostic process (educational

tester, psychologist, and psychiatrist). In addition, RFCL's are completed by the child's parent(s) and regular classroom teacher.[6] The multiple perception of a single pool of problem behaviors has been extremely helpful in facilitating the presentation of a comprehensive picture of a child during staffing. The evaluation team collects and summarizes the data from all of the RFCL's completed. Subsequently, at staffings this information is summarized via a RFCL profile bar graph and summary sheet. The summation of perceived problems thus seems not only to solidify thinking as a staff, but also to reduce the need for detailed diagnostic reports from each staff member. Brief clinic staff reports are given which focus mainly on the possible etiological factors that have been derived through clinical judgment. Allowing for multiple hypctheses in determining the source of a child's problem has proven invaluable for maintaining a flexible treatment approach.

(Pilot testing is planned for the utilization of this same RFCL for the purpose of obtaining post-treatment measures from parents and regular classroom teachers for the detection of problem change, or change perceived by the adults involved.)

Other data are also obtained prior to staffing. Tests measuring such things as social behavior, perceptual-motor development, and academic readiness are administered; intelligence and projective measures are also obtained.

To facilitate program planning and subsequent monitoring, the staffing information is recorded on a three-columned treatment sheet. The first column contains all the high priority problems. The second column contains the suggested causative factors underlying the behavior problems. The third column outlines the treatment focus with specific suggestions for be-

havioral objectives needing emphasis. Recommendations for social work intervention with parents are also specified on the treatment sheet. Having these treatment sheets available for program monitors has been found to be invaluable in providing a framework within which to observe the child and evaluate his progress in the treatment program.

The structuring of the diagnostic staffings in this way has been immensely helpful in pinpointing the needs of a child, setting treatment goals, and outlining treatment procedures. All of these are necessary for the effective evaluation of any program.

Periodic Measurement

Only recently have special educators become more aware of the need for extensive support services when dealing with exceptional children (Haring and Fargo, 1969). This is particularly true with emotionally disturbed children. The use of program monitoring has been an integral part of Developmental Therapy since its inception. A child's needs and behavior can change so rapidly and in such subtle ways that the therapist who is intensely involved with the child often cannot perceive the changes quickly enough. The feeling is that one of the primary mistakes of traditional treatments has been the emphasis on gross change. Restoration of the disturbed child comes, in most cases, from small bits and pieces in the motoric, cognitive, and emotional areas.

The periodic measurement plan at Rutland Center utilizes three diverse measures of behavior obtained unobtrusively during the treatment process: (1) a rating form for the representative objectives, (2) a systematic observational instrument, and (3) a behavioral rating scale. This combination of approaches provides a considerable amount of data; information is obtained from three different perspectives on specified

developmental aspects of a child.

Representative Objectives Rating Form. One outcome measure is obtained from the Representative Objectives Rating Form (RORF). This is a worksheet listing the objectives for each of the four curriculum areas of Developmental Therapy; a space is provided for a mark next to each objective indicating whether the objective has been achieved, is currently a treatment focus, or is not yet appropriate for treatment emphasis. In a consensus session the educational therapist(s) and the monitor assess the child's progress in attaining the prescribed objectives and provide the evaluation team with some quasi-objective evaluative data.

In addition to providing data for evaluative purposes, the completion of such a rating form yields ancillary benefits. First of all, by recording the child's progress through the representative objectives the therapist is kept aware of his therapeutic goals and directions. Furthermore, the task of arriving at agreement on the form through consensus provides a meaningful training opportunity for both the therapist and the monitor.

Systematic Who-to-Whom Analysis Notation. The most frequent means of evaluating change resulting from psychotherapy is the therapist's impressions (Steisel, et al., 1960). Such impressions have been often phrased in global terms, and thus specificity for adjustments in treatment reprogramming have generally been difficult. Emphasis on measuring qualitative aspects of behavior has been properly placed on the other two instruments. It was felt that an overt behavioral measurement approach focusing on the quantitative aspects of behavior that are subject to observation was needed. Such an approach, which requires a minimal

amount of subjective judgment, was chosen for its relative objectivity, i.e., a selected behavior occurs or does not occur.

Quantification of overt behavior is not an innovative approach to the measurement of behavior. This type of measurement has been defined by Medley and Mitzel (1963) as process, or interaction, analysis. Simon and Boyer (1970) describe a variety of observational instruments for use with children and teachers in classroom situations. The basic analytical element of any observational system is the individual interacting with someone or something. A particular observational system provides a method of encoding behavior such that the result is meaningful in the way specified by the user of the system. Many observational systems measure primarily verbal behavior, while few measure physical behavior, and fewer still measure some combination of the two. Some systems require the video-taping of behavior because of the sophistication of the encoding system. A few observational systems provide for the encoding of behavior while the behavior is occurring, such as Spaulding's CASES and Flanders' and Ober's systems (see Simon and Boyer, 1970).

The nature of the therapeutic program at Rutland Center specified the need for an in-process encoding instrument based on the objectives of Developmental Therapy. Such an instrument would enable the observer to concentrate on one child and his environment at any specified time. A review of the available observational systems showed no system adaptable to the periodic measurement needs of Rutland Center. A who-to-whom format was deemed necessary since an observer needs to concentrate his observing on one child at a time. An instrument was thus constructed which appears to satisfy the requirements of our situation.

This outcome measure is a behaviorally based observational instrument which is utilized unobtrusively. The instrument, Systematic Who-to-Whom Analysis Notation (SWAN), is composed of twenty-six categories based on the representative objectives specified in Developmental Therapy. Each category measures some subset of the objectives and aims at mutual exclusiveness by encoding particular behavior in one, and only one, category. The system as a whole also aims at exhaustiveness, allowing every behavior to be encoded into some category. . .

Observers are located in one-way vision observation rooms equipped with sound systems. The three-second rule is employed, i.e., one behavior is encoded in each three-second time period. Various protocol requirements are built into the system as described by Swan (1971). The data are encoded on a who-to-whom observation worksheet and provide for reporting information quickly and understandably. . .

Initial reliability investigations have yielded rather impressive findings. Inter-reliability coefficients (Bernstein, 1968) range from .70 to .97.

Clinical Qualitative Behavioral Scale. The third instrument employed in the periodic measurement process is the Clinical Qualitative Behavior Scale (CQBS) which is used to quantify some qualitative aspects of behavior. Many of the problem areas indicated in the RFCL were translated into objectives measurable in behavior terms. However, some objectives implied by the RFCL (e.g., ability to express anger) cannot be evaluated as simply attained, or not attained. Many such behaviors must be viewed on a continuum and therefore evaluated in qualitative terms. It is only when these behaviors impair the child's functioning that they receive special attention. The CQBS allows for

quantification of the clinician's judgment as to the severity of the disordered behavior manifested by the child.

The instrument, developed jointly by the Rutland Center psychologist and psychiatrist, is a 26-item, seven-point rating scale anchored at both ends by descriptions of degree of impairment. Investigations of reliability are currently being performed, and a training program for the use of the rating scale is being developed.

Assessment and Reprogramming

The information obtained from measures on the three instruments[7] is presented to those concerned with the decision-making process regarding the individual child's treatment program. These data are summarized, for the purpose of feedback to the staff, at different time periods. Data from the SWAN are summarized weekly in the form of proportion of time spent exhibiting the various behaviors; each child is observed for one minute per week in each of four different activity periods. Some questions which may be answered by the accumulation of such data week after week are: 1) Are desired behaviors being elicited during each activity period? 2) Which children are responding to which children? 3) What activities are most stressful and/or anxiety provoking? 4) Who is more dominant, the teacher or the class as a group? and 5) Is the activity a proper means for the child to attain his prescribed objective(s)? Data obtained from this instrument are also used in a "summative" sense. The categories are grouped so as to reflect "approriate" or "inappropriate" or "neutral" overt behaviors. Observations are recorded in the first and last two weeks of each ten week period--for each child this amounts to an observation time of eight

minutes at the beginning and eight minutes at the end of the given time period. To obtain a relatively gross picture of change in each child's overt behavior, the proportion of time spent in each of the three category groupings is obtained -- this is also done by class rather than individual child, if such data are requested.

The RORF is used at the middle (fifth week) and end (tenth week) of each quarter; these forms are completed jointly by the therapist(s) and the monitor. For each child the number of objectives attained in each curriculum area is obtained. This information is also examined at a number of consecutive five-week intervals and may thus be considered, in a sense, longitudinal growth data. Data may also be summarized for each class by using the median number of attained objectives.

Data from the CQBS are collected less frequently than with the SWAN or RORF. Consideration for each of the 26 behavioral items is given initially at the time of intake and again within two weeks after a child has begun treatment at the Center. Both completions are for the purpose of obtaining baseline data for planning the treatment program. Subsequently the CQBS is completed as a "post-treatment" measure to help estimate a child's readiness for termination. Changes in the ratings may be examined for each item or, after an adequate norming sample has been observed, changes in component or factor scores (assuming substantial reliability) may be assessed. These changes may be determined for each child or by class.

The decision-making process involves a cooperative effort on the part of the therapist, monitor, psychologist, and evaluator. This process may yield a new group assignment, a different emphasis in therapy, a reassessment of the child's environment outside of the Center, or entry

into the termination process. Hence, a recycling of the child with respect to setting of treatment objectives, focus of therapy, treatment techniques, etc., may result.

Termination and Tracking

Termination is a process which involves a gradual decline in the number of hours in the Center, and a gradual increase in the dependence of the child upon normal experiential settings to maintain appropriate behavior. When it is judged that a child should begin the termination process, he is observed several times in situ by a psychologist, a psychiatrist, and an educational therapist. Conferences are held with his parent(s) and, if appropriate, with his regular classroom teacher. If deemed necessary, additional tests (e.g., developmental and educational) are administered. As the child's contact with Rutland Center is gradually reduced, supportive services are encouraged from such agencies as Boys' Club, recreation department, preschool and day care centers.

It may be possible to continue rendering service to the child after direct Center treatment is terminated. These services make up what is termed "tracking." The detailed tracking procedures are currently being finalized with help from the social work team. Individual tracking plans will be set up for each child. The plans will generally consist of a follow-up of his progress at school and at home. This follow-up is accomplished through a consultation service which involves parent conferences, teacher conferences, and observations by Center staff members. Consultations are planned to occur approximately one month, three months, six months, and one year after termination of direct Center treatment (RFCL data from the parent(s) and school teacher

are collected at these time intervals). Information from these consultations may indicate a need for (1) reactivating direct Center services to the child or parent, (2) referral services to another agency, or (3) extended consultative help to the regular school teacher.

Current and Subsequent Activities

Of course, the current evaluation plan for the service-to-children component will be subjected to an ongoing evaluation itself, with modifications and alternative strategies expected. Some of these changes may come about as a result of the information and practices which will be specified in a near future release of a Curriculum Guide for Developmental Therapy.[8] This guide will include recommendations with regard to materials, classroom environments, types of verbalizations, structure of activities, etc. An attempt to strengthen the evaluation process is being made through numerous ongoing investigations. For example, a validation of the hierarchical order of the objectives in the RORF, as well as norming the objectives on selected samples (for indicating age appropriateness) is currently being planned. Following such analyses and norming, a study of the objectives as particular predictors of emotional growth is anticipated.

Plans for evaluating the service-to-parents and training components of the project are currently being formulated. Included in these plans are instruments measuring attitudes as well as questionnaire-type instruments. Once all of the service programs become fairly well defined, and general evaluation plans corresponding to these programs have been implemented, it will be possible to investigate relationships between and among various curriculum, therapist, parent, and trainee variables.

FOOTNOTES

1. Dr. Mary M. Wood is acknowledged for her careful reading of an earlier draft of this manuscript.
2. Rutland Center is a demonstration project for the treatment of emotionally disturbed preschool and primary school age children through a psychoeducational approach. This project is supported in part by a grant from the Georgia Department of Education and by a grant from the U. S. Office of Education, Bureau of Education for the Handicapped, under the Handicapped Children's Early Education Assistance Act, P. L. 91-230, Part C, formerly P. L. 90-538.
3. Developmental Therapy is a psychoeducational process for the amelioration of emotional and behavioral disorders in preschool children by the simulation of normal childhood experiences promoting behavioral, communicative, social, and cognitive development. For a complete description see Wood (submitted for publication).
4. Quantification of basically subjective or qualitative aspects of behavior.
5. This list, as well as any evaluative instruments subsequently discussed, are available from Rutland Center upon request.
6. During intake interviews social workers assist the parent in completing the RFCL, as well as obtain pertinent demographic data. Educational therapists likewise assist the regular classroom teachers in completing the RFCL.
7. An additional source of information is in the form of reports of Center staff members who periodically visit with the individual child's regular or nursery school administrator and/or teacher,

and make in-the-classroom observations of the child's behavior.

8. This guide is expected to be completed by October, 1972, and will be available at that time.

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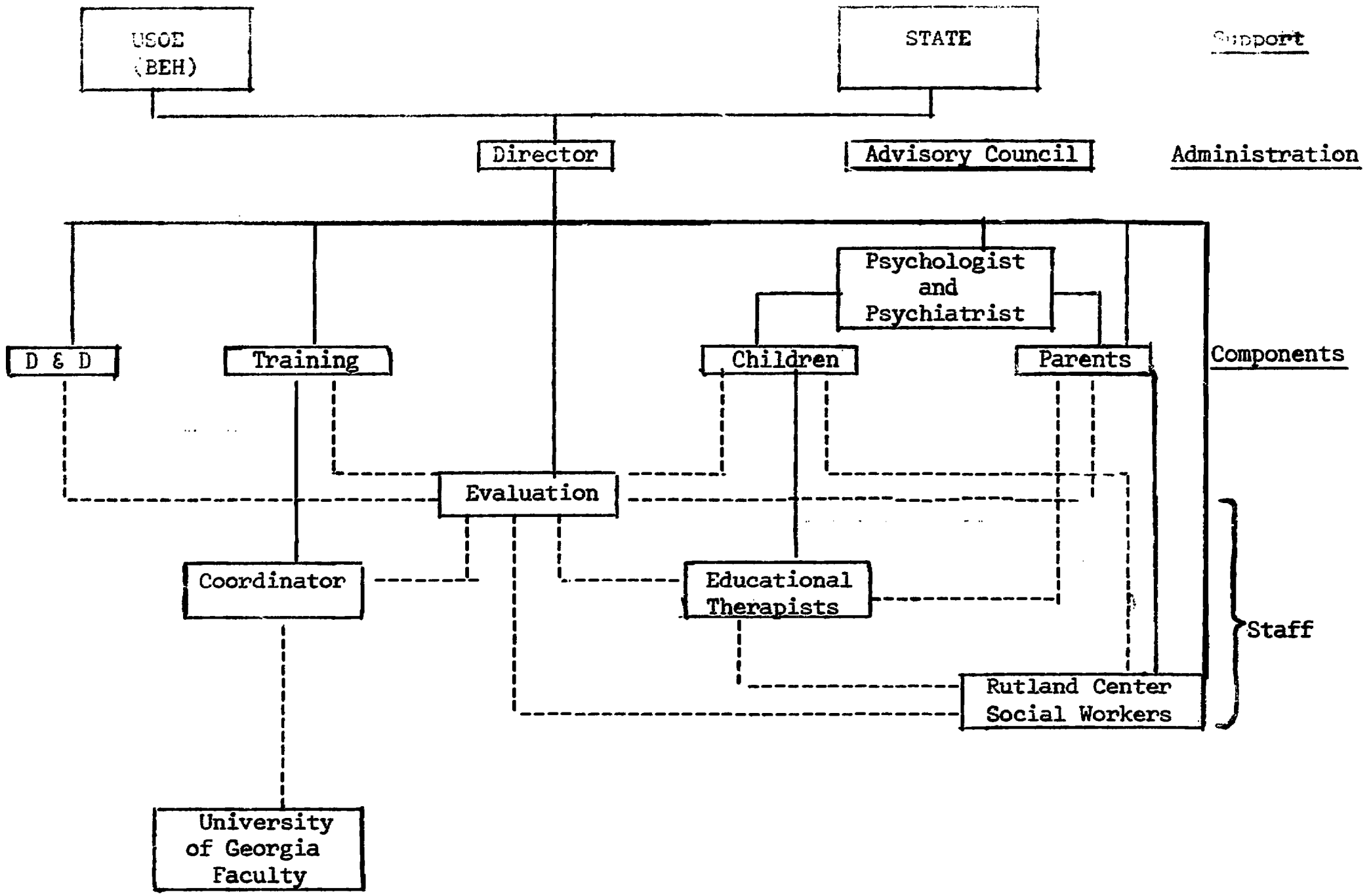

Figure 1
System of Information Exchange

(The solid lines indicate direct communication links that are based on the requirements of the project; the dash lines represent desirable communication links that depend upon intra-system rapport and cooperation.)

Figure 2

THE EVALUATION PROCESS

Type of Activity	Function or Role	Method
Planning	Identify and assess needs and problems State treatment goals and objectives Identify and assess (alternative) strategies	Discussion with director, psychologist and evaluation team
	Implementation design Determine instrumentation for evaluation	Review of research; discussion involving director, psychologist, teachers and evaluation team
	Identify individual treatment objectives	Checklist, intake assessment, staff discussion
	Collect baseline data	Checklist, Intake assessments Observation
Monitoring	Collect data pertaining to treatment effect (periodic assessment)	Behavioral observation form Objectives rating form Clinical rating form Questionnaire and scales for parents and trainees Discussion with monitors
	Relate data to treatment objectives and process (feedback to staff)	Summary and analysis of collected data
	Assess proposal objectives Implementation evaluation	Inventory (completed by evaluator); questionnaires (completed by staff, parents, university dept. members)
Appraising	Devise criteria for concluding that treatment objectives have been attained	Inspection of collected data and discussion with staff
	Relate outcomes to objectives	Analysis of collected data
	Support decisions with regard to outcomes, recycling, reprogramming, termination	Discussion with director, psychologist, and therapist

Figure 3

The Evaluation Plan for Services to Children